MONTANA
Department of Public Health & Human Services

CASE MANAGEMENT SERVICE AGREEMENT PLAN

MONTANA
BREAST & CERVICAL HEALTH PROGRAM

Date Initiated _____ **Administrative Site** _____
Case Manager _____

Last Name:	**First Name:**	**Social Security Number:**

BREAST FOLLOW-UP

Procedure Scheduled < 60 days of abnormal finding	**Provider Name**	**Appointment Date**	**Appointment Re-Scheduled**	**Results**	**Completion Date/Initial**
☐ **Diagnostic Mammogram**					
☐ **Breast Ultrasound**					
☐ **Surgical Consult/Repeat Breast Exam**					
☐ **Fine Needle Biopsy/Cyst Aspiration**					
☐ **Biopsy**					
☐ **Other (specify):** _____					

CERVICAL FOLLOW-UP

Procedure Scheduled < 60 days of abnormal finding	**Provider Name**	**Appointment Date**	**Appointment Re-Scheduled**	**Results**	**Completion Date/Initial**
☐ **GYN Consult**					
☐ **Colposcopy with Directed Biopsy,ECC**					
☐ **Other (specify):** _____					

Monitoring Dates:
Weekly, until date of final diagnosis or application for Medicaid treatment is made (if needed) and treatment initiated

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Lost to follow-up/Refusal: Contact Attempts

Contact Method	**Date**	**Result**
☐ Telephone	_____	_____
☐ Telephone	_____	_____
☐ Telephone	_____	_____
☐ Letter	_____	_____
☐ Certified Letter	_____	_____